DEATH CLAIM INTIMATION FORM INDIVIDUAL POLICY CLAIMS

AFFIX BRANCH SEAL

Instruction for filling up the form

- This claim intimation should be mandatorily accompanied by a valid claim event proof document.
- This claim shall be considered valid only on submission of a proper claim event documents.
- NAV shall be provided as on the Date of Valid Claim intimation if submitted up to 3 pm or the next working day of the valid claim intimation date.
- Every field should be properly, correctly and completely filled up.
- This form is to be filled for ALL DEATH Claims – Death of the Life Insured or Death of the Policyholder, where **Waiver of Premiums rider** has been opted for.
- This form needs to be filled up by the Policyholder, if different from the Life Insured or the Assignee if the policy is assigned or the Nominee registered with KLI as the case may be. In case, the Policyholder / Assignee / Registered Nominee have died at the time of this intimation, then this form needs to be filled up by the respective legal heirs.
- Please submit this form along with the requirements mentioned below at your nearest branch or Claims Department, 7th Floor, Zone -2 Kotak Infiniti, Building no. 21, Infinity Park, Off Western Express Highway, General A K Vaidya Marg, Malad (E), Mumbai – 400 097.
- The Company reserves the right to call for any information / additional document(s) / Requirement(s) as it may deem necessary.

Photograph of the Claimant

(Please affix signature across the photograph)

1. Policy Details (Kindly provide all policy numbers incase if Insured Person had multiple policies)

Documents to be submitted	**Natural Death**		**Unnatural Death**	
Mandatory Documents	Req	Y/N	Req	Y/N
Duly filled Death Claim Intimation Form				
Original Policy Documents				
Original Death Certificate issued by municipality or equivalent authority				
Claimant's Photograph, Current Address Proof and Photo ID Proof				
Copy of bank passbook/statement of the claimant bearing IFSC Code				
Supporting Documents				
Medical certificate stating cause of death			×	
Medical Records (Consultation notes, treatment records, admission notes, hospital indoor papers, discharge / death summary, investigation reports etc)				
Medical Questionnaire / Physician Statement			×	
Copy of duly certified First Information Report /Inquest / Panchnama (translation mandatory in case vernacular language)	×			
Copy of duly certified Post Mortem Report / Chemical Analysis Report (Viscera)	×			
Copy of Driving License if the Insured Person was driving the vehicle at the time of accident.	×			
Settlement Option Form as applicable (refer point # 3)				
Any other Document (Please specify)_____				

2. Details of Claimant: (Current Address Should Match with the Address Proof Provided)

Name (Full Name)								
Maiden Name (Full Name)								
Date of Birth	D	D	M	M	Y	Y	Capacity in which claim is made	☐ Nominee ☐ Propose ☐ Appointee ☐ Assignee ☐ Legal Heir
COMMUNICATION ADDRESS OF THE CLAIMANT							Kindly tick the address proof submitted	

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State: Pin code:	☐ Passport ☐ Voter Identity Card ☐ Driving License ☐ Electricity Bill ☐ Ration card ☐ Bank Statement /Passbook updated till the previous month ☐ Aadhar Card ☐ Valid Lease Agreement with rent receipt of recent 3 months ☐ Telephone Bill ☐ Any other (Kindly Specify) _ _____
Telephone STD LAND LINE	**Mobile No**
Relationship with Insured Person	**EMAIL ID**
Bank A/c Details Bank Name	Branch Name & Address
A/C No.	IFSC Code

I HEREBY GIVE MY CONSENT TO DIRECT CREDIT / NEFT / RTGS CLAIM AMOUNT IN MY ACCOUNT: ☐ YES ☐ NO

3. Payment Option Details:

Kotak Smart Advantage Plan (107L043V01) / **Kotak Head start Future Protect** (107L037V01/ 107L038V01) / **Kotak Long Life Secured Plus** (107L044V01) (Please tick as applicable)**

☐ Lump Sum ☐ Installment

For Kotak Premier Endowment Plan 107N079V01, kindly fill up the separate settlement option form specific to the plan.

***Kotak Retirement Income Plan(All variants except KRIP with Cover)** (107N013V01 / 107N014V01 / 107L031V01 / 107L033V01 / 107L032V01 / 107L024V01 / 107L026V01 / 107L025V01) **/ *Kotak Secure Retirement Plan** (107L049V01) / ***Kotak Guaranteed Pension Builder** (107L057V01) / ***Kotak Second Innings Plan** (107L052V01 / 107L052V02) (Please tick as applicable)

☐ Entire Amount as Lump Sum ☐ Entire Amount as Annuity ☐ Part as Annuity part as Lump Sum

*I further declare that I will bear any tax liability accuring to me on account of taking the full refund of the amount instead of purchasing an annuity.

Prevailing tax laws will be applicable during the payment of the claim.

4. Basic Details of Insured Person:

Name (Full Name)							
Maiden Name (Full Name)							
Date of Birth	DD MM YYYY			Qualification			
Occupation	Employed	Self Employed	Others (Specify)		Income		
Address: (PERMANENT)				(CURRENT)			
State		Pin Code		State		Pin Code	

5. Employment Details of Insured Person:

Last Business / Employer Name					
Address (With landmark)					
Nature Of Work		Designation		Last Working Day	

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EMAIL ID		Contact No (Landline / Mobile)	

6. Details of Death of Insured Person:		
Date of Death	DATE :	TIME :
Place of Death (Hospital, Home, Any other place)		
Type of Death (PLEASE TICK).	NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ MURDER ☐ OTHERS ☐	
Cause of Death and Event Leading to Death		
Doctor / Hospital Contacted at the time of Death		
How Long was the Insured Person suffering from these symptoms		
Details of Doctor / Hospital Contacted first		

7. To be Filled in case of Unnatural Death (Kindly elaborate the specific unnatural claim event e.g. accidents, burns etc):	
Details of Unnatural Death	
Details of the Doctor / Hospital contacted	

8. Details of Past History of Health / Habits of Insured Person		
Nature of medical condition / habit (Please tick the relevant box)	Duration / First Date of Diagnosis	If yes, give details (Kindly attach all medical documents)
Hypertension ☐ Diabetes ☐		
Heart Disease ☐ Liver Disease ☐ Kidney Disease ☐ Cancer ☐ Respiratory Disease ☐		
Any other ailments / disorder/surgery /hospitalisation		
Alcohol ☐ Smoking ☐ Tobacco ☐ Narcotics in any form ☐		

9. Details of Family Physician:	**Name of Clinic / Hospital:**	
Address:		
Telephone STD LANDLINE	Mobile No.	
EMAIL ID		

10. Particulars of Other Life Insurance Policies [PLEASE MENTION DETAILS OF EVERY POLICY HERE]				
Name of the Company	Policy No	Risk Commencement Date	Sum Assured	Status of Claim (Paid / Rejected / Pending)

11. Authorization & Declaration

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Notwithstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital or any other authority from divulging any knowledge or information acquired by him / her / them in attending upon or examining a person on the ground of secrecy, I hereby authorize any physician and any Hospital who has attended upon or examined or treated the aforesaid deceased life assured for any ailment or illness or any other authority to divulge any knowledge or information regarding the deceased's state of health which he / she / they may have acquired whether before or after the policy was issued by Kotak Mahindra Life Insurance Company Limited., to any of the authorized representatives of Kotak Mahindra Life Insurance Company Limited or at any of its offices or in any court of law.
I, _____, do hereby; declare that the statements made herein above are true and complete in each and every respect. I understand that any incorrect or incomplete or misleading information in this form shall affect the claim settlement process and the decision of the Company. I agree to assist the Company in Claims Investigation. I also understand that in furnishing claim forms, Kotak Life Insurance has not admitted liability or waived any of its rights.

*** *Note: "The company cautions against payment of any charges/monies as against claim processing fees to any authorized/unauthorized agency/person claiming the same. Company does not charge any fees for claims process and instructs any such action to be brought to its notice."*

Signed at: _____ **Date:** _____/_____/_____ **Signature / Thumb Impression of the Claimant**_____

Witness Details:

Name of Witness: Contact No. :

Address: Relationship with claimant: _____

Signed at: _____ **Date:** _____/_____/_____ **Signature of Witness:** _____

12. 12.Authorization to Company Representatives to Contact the Claimant & Family

I, Mr. /Mrs. /Ms _____, having _____ (Mobile number) _____(Landline)_____ (email id) have applied for a claim under the aforesaid insurance policy(ies) of Kotak Life Insurance (Company), hereby authorize the Company and any of its representatives to make calls / SMS's / emails or personal visits for documentation / requirement or any other enquiry in relation to the aforesaid claim.

I also undertake that for such enquiry calls / SMS's in relation to the aforesaid claim, made by the Company and its representative, I shall not lodge a complaint for violation of TRAI guidelines on unsolicited phone calls and SMS's.

Signed at: _____ **Date:** _____/_____/_____ **Signature / Thumb Impression of the Claimant**_____

Witness Details:

Name of Witness: Contact No. :

Address: Relationship with Claimant : _____

Signed at: _____ **Date:** _____/_____/_____ **Signature of Witness:** _____

[Please fill, if the claimant has signed in a vernacular language or has affixed his / her thumb impression]
Full Name of the Scribe :
Contact No. : Date of Birth: Relationship with Claimant :
Complete Address :
Signed at: _____ **Date:** _____/_____/_____ **Signature of the Scribe:**_____

This is just an intimation of Claim to the Company. This intimation is not admittance of the Claim by the Company.

☐ **Intimation**